**County of San Bernardino Department of Behavioral Health**
**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

| Name of Client: _____ | Date of Birth: _____ Month/Day/Year |
|---|---|
| Sex: ☐ Male ☐ Female | Social Security: ____-____-____ |

**Completion of this document authorizes the release, disclosure and/or use of health information about you. Failure to provide all information requested may cancel this Authorization.**

## USE AND DISCLOSURE OF HEALTH INFORMATION

**I hereby authorize** _____ **to release to:**

(1) Name: _____
Address: _____

(2) Name: _____
Address: _____

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received – ***OR***
☐ Only the following records or types of health information (including any dates):

b. I specifically authorize release of the following information (check as appropriate):
☐ Mental health treatment information
☐ HIV test results
☐ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

## PURPOSE

Purpose of requested use or disclosure: ☐ patient request; ***OR*** ☐ other:

_____
_____
_____
_____
_____
_____

## County of San Bernardino Department of Behavioral Health
## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

**To Agencies Receiving This Information:** This information is protected by state and federal laws and should not be given to anyone else not included on this Authorization without a new Authorization from the client, unless otherwise authorized by law. If you have received alcohol and/or drug assessment, treatment, or referral program information, the following applies: **This information has been disclosed to you from records protected by Federal confidentiality law/rule (42 CFR, Part 2). The Federal rules forbid you from making another/any further release/disclosure of this information unless expressly/specifically permitted by the written consent of the person signing this Authorization or as allowed by Federal law/rule (42 CFR, Part 2). A general Authorization of medical or other information is NOT sufficient for this purpose. The Federal laws/rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

### MY RIGHTS

I may refuse to sign this Authorization. It will not affect my ability to get treatment.

I have a right to receive a copy of this Authorization.

To the extent permitted by law, I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but must do so in writing and submit it to the following address:_____

_____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Information released by this Authorization could be re-released by whoever receives it, and the re-release is in some cases not protected by California law and may no longer be protected by federal confidentiality law (, HIPAA).

### SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____

*(patient/representative/spouse/financially responsible party)*

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness: _____